

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-048059

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 299

VS 300  
Rev. 4/5910928  
24014

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DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

1. PLACE OF DEATH a. COUNTY <b>St. Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Charles</b>		Length of stay in 1b <b>D.O.A.</b>	c. CITY OR TOWN <b>St. Ann.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Josephs Hospital</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3442 St. Joachim La.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles E. Green</b>			4. DATE OF DEATH Month Day Year <b>Dec. 13, 1962</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/1897</b> 9. AGE (last birthday) <b>65</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sprinkler Fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sprinkler Fitter</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b> 12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13a. FATHER'S NAME <b>Harvey Green</b>		13b. MOTHER'S MAIDEN NAME <b>Eliza Keene</b>	14. NAME OF HUSBAND OR WIFE <b>Margaret Green</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT Address <b>Margaret Green 3442 St. Joachim La.</b>
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <b>OCT 27, 1962</b> to <b>DEC 13, 1962</b> and last saw him alive on <b>DEC 4, 1962</b> Death occurred at <b>D.O.A. arrival at Hospital</b> on the date stated above, and to the best of my knowledge, from the causes stated. <b>10:00 A.M.</b>			
22a. SIGNATURE (Degree or title) <b>W.A. McElrath, M.D.</b>		22b. ADDRESS <b>8711 St. Charles Rd #4</b>	22c. DATE SIGNED <b>12/13/62</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>12/15/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Lebanon Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Ann, Mo.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Collier Mortuary, St. Ann, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>Dec 13, 1962</b>	26. REGISTRAR'S SIGNATURE <b>Marcella Wilson</b>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.

BY AFFIDAVIT OF

DEC 27 1962

# STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address St. Ann Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.